1. National Uniform Billing Committee [NUBC]

- UB04.
  - UB04 Manual available June 1, 2005
  - Print specifications will be made available on the NUBC website: www.nubc.org
  - UB04 can be used as of March 1, 2007 and REQUIRED as of May 23, 2007

The UB-04 is scheduled to replace the UB-92 beginning with bills created on March 1, 2007 in accordance with the following transition:

• March 1, 2007 – Health plans, clearinghouses, and other information support vendors
should be ready to handle and accept the new UB-04 form and data set.

• March 1 to May 22, 2007 – Providers can use either the UB-04 or UB-92 forms/data set
specifications.

• May 23, 2007 – The UB-92 is discontinued; only the UB-04 form and data set specifications should be used. All rebilling of claims must use the UB-04 from this date forward, even though earlier submissions may have been on the UB-92.

For information on obtaining full color proofs of the form for testing purposes, or a beta release of the corresponding data specifications manual, contact NUBC at www.nubc.org.

2. National Uniform Code Committee [NUCC]

Update on 1500 Claim Form

June 6, 2006:
The current version (12/90) of the 1500 Claim Form was renewed by OMB on 5/30/06. The renewal of the current form was necessary to allow for its continued use during the transition period to the revised form.

The revised version (08/05) is still under review by OMB. The NUCC sent a letter to OMB on May 30, 2006 urging them to expedite the approval of the revised form.

At the May NUCC meeting, **CMS announced that the necessary systems changes required for them to accept the revised form will not occur with the October 1, 2006 release.** This delay was a result of a cutback in contractor work hours by the agency. A new request is being submitted for the systems changes to occur with the January 1, 2007 release. CMS will know in July if this request has been accepted.

On May 30, 2006, the NUCC sent a letter to CMS urging them to expedite the implementation of the revised form due to the fact that it is integral for the industry to transition to the NPI. Another letter was sent to NCVHS asking for their assistance in getting the form approved by OMB and implemented by CMS. The importance of the form was emphasized in this letter.

At this time, there has been no change to the NUCC's recommended timeline for transitioning to the revised form. Any decisions to change these dates are pending approval of the form by OMB and notification from CMS of the release date for the systems changes.

The NUCC has recommended that the health care industry adopt the following timeline for the transition to the new version of the 1500 Health Insurance Claim Form (version 08/05).

- October 1, 2006: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised (08/05) 1500 Claim Form.
- October 1, 2006 – February 1, 2007: Providers can use either the current (12/90) version or the revised (08/05) version of the 1500 Claim Form.
- February 1, 2007: The current (12/90) version of the 1500 Claim Form is discontinued; only the revised (08/05) form is to be used. All rebilling of claims should use the revised (08/05) form from this date forward, even though earlier submissions may have been on the current (12/90) 1500 Claim Form.

3. NPI – National Provider Identifier

- CMS NPI Timelines:

  The Centers for Medicare and Medicaid Services announces the following plans for transitioning to the National Provider Identifier (NPI) in the Fee-for Service Medicare Program:

  Between May 23, 2005 and January 2, 2006, CMS claims processing systems will accept an existing legacy Medicare number and reject, as unprocessable, any claim that includes only an NPI.

  Beginning January 3, 2006, and through October 1, 2006, CMS systems will accept an existing legacy Medicare number **or** an NPI as long as it is accompanied by an existing legacy Medicare number.

  Beginning October 2, 2006, and through May 22, 2007, CMS systems will accept an existing legacy Medicare number **and/or** an NPI. This will allow for 6-7 months of provider testing before only an NPI will be accepted by the Medicare Program on May 23, 2007.

  Beginning May 23, 2007, our systems will **only** accept an NPI.
  For additional information, to complete an NPI application, and to access educational tools, visit https://nppes.cms.hhs.gov on the web.

- National Enumeration Statistics as of May 31, 2006:

NATIONAL PLAN AND PROVIDER ENUMERATION SYSTEM

NPI Enumeration Statistics by State / Entity Type

As of : 05/23/2005 through 05/31/2006

State	Individual	Organization	Total
AK	1213	185	1398
AL	6242	1422	7664
AR	4398	1449	5847
AS	8		8
AZ	11377	1728	13105
CA	31450	7376	38826
CO	8368	1400	9768
CT	7362	952	8314
DC	1919	98	2017
DE	1605	311	1916
FL	32141	7568	39709
FM	6	2	8
GA	12256	2462	14718
GU	103	16	119
HI	2038	268	2306
IA	7483	1823	9306
ID	1890	472	2362
IL	17172	3881	21053
IN	11485	2254	13739
KS	5647	1669	7316
KY	7499	1702	9201
LA	6097	1777	7874
MA	19012	2062	21074
MD	10978	1747	12725
ME	2484	543	3027
MH		1	1
MI	15632	3018	18650
MN	14148	1707	15855
MO	9970	2311	12281
MP	1	1	2
MS	2016	816	2832
MT	1182	371	1553
NC	16669	3736	20405
ND	631	271	902
NE	3077	786	3863
NH	2234	491	2725

State	Individual	Organization	Total
NJ	12497	2478	14975
NM	3185	503	3688
NV	3224	588	3812
NY	33677	4586	38263
OH	21782	4537	26319
OK	6118	1405	7523
OR	6009	986	6995
PA	30052	6583	36635
PR	4850	988	5838
PW	1	6	7
RI	2375	354	2729
SC	7342	1908	9250
SD	2111	509	2620
TN	11380	2088	13468
TX	29917	7365	37282
UT	3047	645	3692
VA	14279	1945	16224
VI	60	12	72
VT	968	244	1212
WA	10185	1630	11815
WI	11736	1946	13682
WV	3149	766	3915
WY	778	203	981
FOREIGN COUNTRIES	2330	62	2392
	496845	**99013**	**595858**

---The health care providers in FOREIGN COUNTRIES category are primarily U.S. military providers who are stationed in foreign countries.

- **New FAQs from CMS**

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_lva=&p_li=&p_page=1&p_cat_lvl1=2&p_cat_lvl2=25

ID = 7302
Date Created = 05/22/2005
Last Updated = 05/23/2006

Why do I need my National Provider Identifier (**NPI**) now, when I've been told it's not required until 2007?

While it is true that providers and suppliers will need to use their **NPI** in all electronic transactions beginning May 23, 2007, Medicare is requiring the submission of the **NPI** with the enrollment application for the following reasons:

1. It enables Medicare to build and validate its crosswalk in a timely manner; and,
2. It will enable Medicare and providers to assure timely claims payment at the deadline.

Finally, the **NPI** Final Rule does not prohibit any health plan, including Medicare, from requiring providers and suppliers to submit their **NPI** prior to the May 23, 2007 compliance date.

- **Updated FAQs from CMS**

ID = 5815
Date Created = 09/21/2005
Last Updated = 05/12/2006

Question:
After the compliance date for the **NPI**, can a covered health care provider (a health care provider who sends covered transactions electronically) continue to use other numbers, such as legacy or proprietary identifiers, in addition to its **NPI**, to identify itself as a health care provider in standard transactions?

Answer:
No. After May 23, 2008 for standard transactions to or from small health plans, and after May 23, 2007 for all other standard transactions, a covered health care provider may use only its **NPI** to identify itself as a health care provider.

The **NPI** Final Rule requires covered entities to use the **NPI** of any health care provider (or subpart, if appropriate) that has been assigned an **NPI** to identify that health care provider as a health care provider in standard transactions (45 CFR 162.412(a) and 162.414). This means that health care providers who are not covered health care providers, but who have been assigned NPIs, will be identified in standard transactions as health care providers only by their NPIs, just as covered health care providers will be identified in standard transactions as health care providers by their NPIs.

ID = 5816
Date Created = 09/21/2005
Last Updated = 05/12/2006

Question:
How do covered entities implement the NPI in accordance with the NPI Final Rule, where the adopted versions of the Implementation Guides for the standard transactions (X12N version 004010 as modified

[004010A1], and the NCPDP Telecommunication Standard Implementation Guide, Version 5, Release 1, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 [Version 1.1]) appear to allow the use of other health care provider identifiers in addition to the NPI?

Answer:
Background

Section 1173(b) of HIPAA required the Secretary to adopt "standards providing for a unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system." Congress intended that the unique health identifier for health care providers be used by covered entities to identify health care providers as such in standard transactions. The Secretary adopted the National Provider Identifier (NPI) as the standard unique health identifier for health care providers. The final rule that adopted the NPI was published on January 23, 2004; the effective date is May 23, 2005. Compliance dates are May 23, 2007 for all covered entities except small health plans; small health plans must comply by May 23, 2008. All entities that meet the regulatory definition of "health care provider" (at 45 CFR 160.103) are eligible for NPIs. Covered health care providers must obtain and use NPIs. Covered health care providers who are organizations must determine if they have subparts that need to be assigned NPIs; if so, they must ensure that the subparts obtain NPIs and use them in standard transactions.

In the Transactions Rule (published on August 20, 2000), the Secretary adopted standards for certain health transactions and implementation specifications for those transactions. On February 20, 2003, in the Modifications to Electronic Data Transaction Standards and Code Sets, the Secretary, among other things, adopted modifications to some of the implementation specifications. Implementation specifications are the specific instructions for implementing a standard. The instructions, known as Implementation Guides, are prepared by the maintainers of the standards and are made available to the public by the Washington Publishing Company at www.wpc-edi.com. The implementation specifications for the adopted transaction standards are the X12N Implementation Guides, version 004010 as modified (004010A1), and the NCPDP Telecommunication Standard Implementation Guide, Version 5, Release 1, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1).

The NPI Final Rule and the adopted implementation specifications (Implementation Guides)

The NPI Final Rule requires that, by the compliance dates, covered entities use the NPI of any health care provider or subpart of a covered entity that has been assigned an NPI to identify that health care provider in all standard transactions where that health care provider's identifier is required. Covered health care providers must use only their NPIs to identify themselves as health care providers in standard transactions, and must ensure that their subparts do the same. The Implementation Guides referred to above were adopted before the NPI was adopted as the standard unique health identifier for health care providers. The Implementation Guides attempted to accommodate the usage of a HIPAA-mandated health care provider identifier in standard transactions; but because there was no HIPAA standard unique health identifier adopted at that time, the authors of the Implementation Guides could not know exactly how the later-adopted NPI would be used. As a result, in some instances, there is confusion about how to reconcile the Implementation Guides with the requirements of the NPI Final Rule. For example, in some loops, under certain situations, the Implementation Guides permit the use of the NPI and a secondary identifier; the NPI Final Rule, however, explains that the NPI, in standard transactions, replaces all health care provider identifiers previously used to identify health care providers as such. In other instances, the Implementation Guides are not clear as to the appropriateness of the use of the NPI in some of the loops and data elements within the standard transactions, primarily within the X12N transactions. Those ambiguities will be eliminated when modifications to the standard transactions are adopted at some future time. However, the NPI Final Rule sets forth rules for using the NPI that enable reconciliation with the Implementation Guides, as discussed below.

Note that this guidance applies to standard transactions on and after the NPI compliance dates. During the transition period (that is, from the NPI effective date until the NPI compliance date(s)), covered entities may consider using the NPI as the primary health care provider identifier, and other health care

provider identifiers allowed by the Implementation Guides as the secondary identifier, so that crosswalks between the NPI and the other identifiers can be constructed by health care clearinghouses and health plans.

We offer the following guidance concerning the use of the NPI in standard transactions:

After May 23, 2008 for standard transactions to or from small health plans, and after May 23, 2007 for all other standard transactions:

• A covered health care provider must use only its NPI to identify itself as a health care provider in standard transactions. If any of its subparts have been assigned NPIs, the covered health care provider must ensure that the subparts use only their NPIs to identify themselves as health care providers in standard transactions.
• Health plans and health care clearinghouses must use the NPI of any health care provider or subpart who has been assigned an NPI to identify that health care provider or subpart as a health care provider in standard transactions.
o In standard transactions designed to capture a Primary and a Secondary Identifier for a health care provider, the NPI (once it is assigned) must be used as the Primary Identifier. When the NPI is used as the Primary Identifier, the only identifier that can be reported as the secondary identifier is the Taxpayer Identification Number (TIN) if the Implementation Guide requires the reporting of the TIN for tax purposes. A Secondary Identifier must not be reported unless it is required to be reported to capture a TIN. This guidance applies to the following loops in X12N transactions: Billing Provider, Pay-to Provider, Service Facility (837 Institutional/Professional/Dental); Attending Physician, Operating Physician, Other Provider (837 I); Referring Provider, Rendering Provider (837 P/D); Purchased Service Provider, Supervising Provider, Ordering Provider (837 P); Assistant Surgeon (837 D); Provider Information (270/271), Requester Name (278 Request/Response); Service Provider Name (278 Request/Response, 835); Information Receiver (270/271); Provider Name (276/277).
o In standard transactions designed to capture a single identifier for a health care provider, the NPI must be used as that identifier.
• If a covered entity needs to identify a noncovered health care provider who does not have an NPI in a standard transaction, the noncovered health care provider:
o Must be identified by its SSN or EIN as its Primary Identifier in standard transactions designed to capture a Primary and a Secondary Identifier for a health care provider. The Secondary Identifier would be reported in accordance with the qualifiers listed in the Implementation Guides for those transactions.
o Must be identified by one of the qualifiers (other than the qualifier for the NPI) listed in the Implementation Guides for the standard transactions that are designed to capture a single identifier for a health care provider.

Keeping in mind the information above, we offer guidance specifically related to the X12N and NCPDP Implementation Guides.

X12N Implementation Guides

The X12N Implementation Guides for standard transactions (version 004010A1) are designed to capture a variety of information in addition to the information that specifically identifies health care providers and subparts as health care providers.

X12N Implementation Guide Legend
820 Payroll Deducted and Other Group Premium Payment for Insurance Products
834 Benefit Enrollment and Maintenance
837 P Health Care Claim: Professional
837 I Health Care Claim: Institutional
837 D Health Care Claim: Dental
835 Health Care Claim Payment/Advice
270/271 Health Care Claim Eligibility Benefit Inquiry and Response
276/277 Health Care Claim Status Request and Response
278 Health Care Services Review – Request for Review and Response

Below is a list of situations concerning the appropriateness of the use of the NPI:
• The Taxpayer Identification Number (TIN) may be required to identify an entity as a taxpayer. The Internal Revenue Service recognizes a Social Security Number (SSN), an Employer Identification Number (EIN), or an Individual Taxpayer Identification Number (ITIN) as a TIN. The NPI is not a Taxpayer Identification Number and may not be used to identify a health care provider or a subpart as a taxpayer in standard transactions.
• License, certification, registration and similar numbers indicate permission or notification of fulfillment of requirements from appropriate competent authorities for the licensed, certified, or registered health care provider or subpart to perform certain services. The Implementation Guides contain information with respect to when license, certification, and registration numbers are allowed to be reported for the purposes they serve, and require those numbers to be supplied in some instances. The NPI does not represent such permission or fulfillment of licensure, certification, or registration requirements; therefore, it may not be used in lieu of license, certification, or registration numbers where those numbers are called for in standard transactions. Those numbers should continue to be used in the appropriate place.
• Contract Number is used to identify a health care provider. On and after the NPI compliance date(s): If a health care provider or subpart has been identified by its NPI in the standard transaction, the Contract Number may not be used. (Example: In 2100B of the 270/271, "Information Receiver Additional Information," CT-Contract Number is a valid qualifier code/description. If the Information Receiver has already been identified by an NPI, Contract Number may not be used.) (NOTE: This guidance does not pertain to the use of contract information for capitated situations.)
• Submitter Identifier, Receiver Identifier and Information Receiver of the 276/277 are used to identify the submitter and receiver of electronic transactions. Trading partners assign an electronic transmitter identification number (ETIN) for use in X12 transactions, which identifies the entities with whom they conduct electronic transactions. These identifiers distinguish entities as submitters and receivers of EDI transactions for given trading partners. Submitters or receivers may be health plans, health care clearinghouses, billing companies, health care providers, value-added networks, repricers, or other entities. On and after the NPI compliance date(s): Because Submitter and Receiver Identifiers are not used to identify entities as health care providers, the NPI is not required to be used as a Submitter or a Receiver Identifier in standard transactions. However, the NPI may be used as a Submitter or Receiver Identifier if the Submitter or Receiver is a health care provider who has an NPI, and both trading partners agree to use the NPI for such purpose.
• Service Facility Location, 2310D of the 837 P (Loop 2310E of the 837 I), is required when the health care service is conducted in a location different from that carried in the Billing Provider or Pay-to Provider loops. This loop, if it is required to be used, captures the facility name, address, Primary Identifier, and Secondary Identifier. This implementation could be particularly problematic with respect to the NPI if the Billing Provider is a covered organization health care provider who did not designate as a subpart the entity whose location is required for this loop, or if the entity whose location is required for this loop does not otherwise have an NPI (e.g., it is a subpart of some other covered organization health care provider who did not designate it a subpart, or it is a noncovered health care provider who did not obtain an NPI). The designation of an entity as a subpart is a decision made by a covered organization health care provider. Covered organization health care providers will not necessarily designate subparts in the same way. Even after subparts are designated, subparts may not be recognized in the same way by all health plans. On and after the NPI compliance date(s): If the entity that needs to be identified in the Service Facility Location loop has been assigned an NPI, that NPI must be used as the Primary Identifier in this loop, and a Secondary Identifier may not be used. If the entity that needs to be identified in the Service Facility Location loop has not been assigned an NPI, no identifier may be reported in the Primary or Secondary Identifiers in this loop.
• Utilization Management Organization (UMO), 2010A in the 278 Request and Response, is the entity receiving the prior authorization/referral request. It is the "gatekeeper," which is an administrative extension of the health plan, to whom the health plan has given the authority to do utilization review. The UMO may sometimes be a health care provider operating under a contractual relationship with a health plan to perform this service for the health plan for one or more patients. On and after the NPI compliance date(s): Because the UMO is used to identify the "gatekeeper" for the health plan, the NPI is not required to be used. However, the NPI may be used to identify the UMO if the UMO is a health care provider who has an NPI, and both trading partners agree to use the NPI for such purpose.
• Additional Patient Information Contact Name (Loops 2010CB, 2010DB), and Additional Service

Information Contact (Loop 2010F) in the 278 Response, are used in situations where the UMO would need additional clinical diagnosis information before being able to render a decision. The skill set of the additional contacts would be that of a health care provider, so it is possible that these loops identify health care providers. On and after the NPI compliance date(s): Because the Additional Patient or Service Information Contact is used to identify a reviewer of utilization, the NPI is not required to be used. However, the NPI may be used to identify the Additional Patient or Service Information Contact if the Contact is a health care provider who has an NPI, and both trading partners agree to use the NPI for such purpose.

• Information Receiver, 2100B of the 270/271 Eligibility Inquiry and Response, is the entity who will use the eligibility information. That entity is usually a health care provider, but could also be another health plan. On and after the NPI compliance date(s): If the entity that needs to be identified in this loop is a health care provider who has been assigned an NPI, that NPI must be used as the Primary Identifier in this loop, and a Secondary Identifier may not be used. If the entity that needs to be identified in this loop is not a health care provider or is a health care provider who does not have an NPI, use one of the other qualifiers presented in the Implementation Guide for the Primary Identifier and for the Secondary Identifier, if necessary.

• Subscriber/Dependent Benefit Related Entity, 2120 in the 270/271, is used to identify another information source when applicable to the eligibility response. The source may be a health plan, health care provider, or other entity. On and after the NPI compliance date(s): If the entity that needs to be identified in this loop is a health care provider who has been assigned an NPI, that NPI must be used. If the entity that needs to be identified in this loop is not a health care provider or is a health care provider who does not have an NPI, use one of the qualifiers other than the qualifier for the NPI.

NCPDP Implementation Guides

In NCPDP standard transactions, four fields identify health care providers: Prescriber, Primary Care Provider, Provider Identifier, and Service Provider Identifier. On and after the NPI compliance date(s): If a health care provider or a subpart needs to be identified in any of those fields, an NPI must be used if one has been assigned. If an NPI has not been assigned, one of the qualifiers other than the qualifier for the NPI may be used.

Additional Information

The Drug Enforcement Administration (DEA) Number was established by regulation to track controlled or dangerous substances. The DEA assigns this number to certain medical professionals and others who are permitted to prescribe those substances. Over the years, the health care industry expanded its use of the DEA Number, allowing it to be used in a variety of transactions as a general identification number for health care providers who had DEA Numbers. Recent activities by the DEA and some State legislatures are restricting the use of the DEA Number to only that for which it was established. Standard transactions do not require the use of the DEA Number for its regulatory purpose, but some Implementation Guides permit the use of the DEA Number as a general identification number. The NPI may not be used in lieu of the DEA Number when the DEA Number is required to be used for its regulatory purpose. The DEA number cannot be used as a provider identifier in standard transactions by covered entities after the compliance date.

4. X12 Updates:

- **MK's notes from the June 2006 X12 Meeting:**
  IBPAECL Meeting.
  INSURANCE BUSINESS PROCESS APPLICATION ERROR CODE LIST (IBPAECL) MAINTENANCE COMMITTEE

28 new codes for the 824 – came from claims attachment pilot.

1 BIN segment contents not in MIME format
2 Invalid or missing MIME header
3 Invalid or missing MIME boundary
4 Invalid or missing MIME transfer encoding
5 Invalid or missing MIME content type
6 Invalid or missing MIME content disposition (file name)
7 Invalid or missing file name extension
8 Invalid MIME base64 encoding
9 Invalid MIME quoted-printable encoding
10 Invalid MIME line terminator (should be CR+LF)
11 Missing end of MIME headers
12 Missing CDA in first MIME body part
13 Multiple CDA messages not allowed in MIME body parts
14 Error in XML tag or missing XML tag
15 Unrecoverable XML error
16 Data format does not match the HL7 data type
17 Invalid or missing required LOINC answer in the CDA
18 Invalid or missing Provider information in the CDA
19 Invalid or missing Patient information in the CDA
20 Invalid or missing Attachment Control information in the CDA
21 Invalid LOINC code
22 Invalid LOINC modifier code
23 Invalid LOINC code for this attachment type
24 Invalid LOINC modifier code for this attachment type
25 Missing LOINC code for this attachment type
26 Missing LOINC modifier code for this attachment type
27 Missing answer part in CDA
28 Data element must not be used for this transaction based on situational requirements

Claim Adjustment Reason Code Meeting.

Added:
196 – Claim/service denied based on prior payer's coverage determination.

Changed the verbiage, added requirements!!!

The following CARCs will require at least ONE Remark Code be included on the 835 on and after April 1, 2007.
The additional sentence added is:
When this code is used, at least one remittance advice remark code must be provided as supplemental clarification.

16 – Claim/service lacks information which is needed for adjudication
17 – Payment adjusted because requested information was not provided or was insufficient/incomplete.
96 – Non-Covered charges.
125 – Payment adjusted due to a submission/billing error.

Claim status codes.
Will be adding new codes to account for HSAs

CMS Caucus.

Claim attachment is in process. X12 and HL7 are done with their pieces. They are reviewing the comments in common and anticipate completion by the end of this week [June 16th].

Modification Rule is in development. Can't really talk about it. Look for it 'soon'.

E-prescribing is going through clearance, interim final rule will be out soon.

Data dissemination policy is scheduled for an August publishing date.

NPI and the 835. See Change Request #5081.
Will be seeing an end to the 835 contingency period.
New MREP [Medicare Remit Easy Print] version in testing, will be available later this year for the general provider population. They have heard that some commercial/Medicaid's are unhappy when they receive a copy of this because it does not have a Medicare Logo when printed and there is no intent to add one.
Medicare will be moving all providers to EFT.

The following guides were approved for final publication:

5010 276/277
5010 834
5010 820
4050 274 [not HIPAA mandated]

The 5010 837s will be available for purchase from Washington Publishing Company at the end of this month.

270/271 – Eligibility Inquiry and Response

The draft 5010 270/271 TR3 contained 3 new "Required Alternate Search Options." They were:

1) Member ID/DOB
2) Member ID/FN/LN
3) LN/FN/DOB

The third option created some controversy due to fraud and privacy concerns, primarily on the payers part. During the conference, the 270/271 Workgroup (X12N/TG2/WG1) voted to change the third option to an "Alternate Search Option" and to return minimal information on the 271 response. The minimal information is:

> If the individual has coverage (2110C/D loop EB01 status), the service type code (EB03), and the health plan name (EB05).

The new Alternate Search Option was presented at the scheduled Informational Forum and received no opposition. The Workgroup will proceed with updating the 5010 TR3 and move forward in September at the Boston X12 Conference.

Approved a new external code set for the 837 guides:

The public health data consortium has been working on building standards for public reporting. They identified a need for identifying the type of payer on a claim – what kind of payer does the provider expect to pay for the service. They began working on a payer topology that would help better define payer types. PHDC has created a new list that is hierarchical in nature, will keep SBR09 or make it SBR12 – still in the talking phases. The details of how is will appear are up to the architecture group. There was some discussion about just having this code source replacing SBR09. Bob has a copy of the list and will share with the workgroup. This will be an external code list maintained by PHDC. The current list is on their website. Unclear as to what version this change will be made in.

www.phdatastandards.info – pay type committee.

PHDSC Payer Type Committee Request Feedback on Revised Payer Typology

The PHDSC's Payer Type Committee has collaborated with the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project (**HCUP**) state partners to develop a revised version of the draft "Payer Type Typology." The Payer Type Typology was developed to create a payer type standard for reporting payer type data that will enhance the payer data classification. The Payer Type Committee believes that development of a standard Payer Type classification is a high priority for public health and research. We are beta testing the new PHDSC "Payer Type typology" that would enable comparisons of source of payment data across State and other data sources States or payers could use more detailed codes for their own analysis, and then "roll up" those codes to the more aggregate codes in the typology. This would allow comparisons to payer data from other states or source of payment data in other databases. Please click here to access the draft payer typology and additional information about the Payer Type Committee. We welcome your feedback on the draft "Payer Typology." Please send any comments to phdsc@cdc.gov.

Source of Payment Typology (Version 1.0)

01 MEDICARE (SBR09 value - MA or MB)

1. **Medicare (Managed Care)**
   - 1 Medicare HMO (SBR09 value - 16)
   - 2 Medicare PPO
   - 3 Medicare POS
   - 9 Medicare Managed Care Other
2. **Medicare (Non-managed Care)**
   - 1 Medicare FFS
   - 2 Medicare Drug Benefit
   - 3 Medicare Medical Savings Account (MSA)
   - 4 Medicare Drug Benefit (Part D)
   - 9 Medicare Non-managed Care Other
9. **Medicare Other**

02 MEDICAID (SBR09 value - MC)

1. **Medicaid (Managed Care)**
   - 1 Medicaid HMO
   - 2 Medicaid PPO
   - 3 Medicaid PCCM (Primary Care Case Management)
   - 9 Medicaid Managed Care Other
2. **Medicaid (Non-managed Care Plan)**
3. **Medicaid/SCHIP**
4. **Medicaid Applicant**
5. **Medicaid - Out of State**

9. Medicaid Other

03 OTHER GOVERNMENT (Federal/State/Local)
(excluding Department of Corrections)

1. Department of Defense
- 1 CHAMPUS (SBR09 value - CH)
  - 1 Indemnity
  - 2 Managed care
    - 1 TriCare
- 2 CHAMPVA (SBR09 value - CH or VA)
- 9 Department of Defense (not CHAMPUS) (SBR09 value - OF)

2. VA (SBR09 value - VA)
- 1 VA - Priority Veteran
- 2 VA - Enrolled Veteran with Copay
- 9 VA - Other

3. Indian Health Service or Tribe (SBR09 value - OF)
- 1 Indian Health Service - Regular
- 2 Indian Health Service - Contract
- 3 Indian Health Service - Managed Care
- 4 Indian Tribe - Sponsored Coverage

4. HRSA Program (SBR09 value - OF)
- 1 Title V (MCH Block Grant) (SBR09 value - TV)
- 2 Migrant Health Program
- 3 Ryan White Act
- 9 Other

5. Black Lung (SBR09 value - OF)

6. State Government (SBR09 value - 11)
- 1 State SCHIP program (codes for individual states)
- 2 Specific state programs (list/ local code)
- 9 State, not otherwise specified (other state)

7. Local Government (SBR09 value - 11)
- 1 Local - Managed care
  - 1 HMO
  - 2 POS
  - 3 PPO
- 2 FFS/Indemnity
- 9 Local, not otherwise specified (other local, county)

8. Other Government (Federal, State, Local not specified) (SBR09 value - OF or 11)
- 1 Federal, State, Local not specified - FFS
- 2 Federal, State, Local not specified - HMO
- 3 Federal, State, Local not specified - PPO
- 4 Federal, State, Local not specified - POS
- 9 Federal, State, Local not specified - Other

9. Other Federal (SBR09 value - OF)

04 DEPARTMENTS OF CORRECTIONS

1. **Corrections Federal (SBR09 value - OF)**
2. **Corrections State (SBR09 value - 11)**
3. **Corrections Local (SBR09 value - 11)**
4. **Corrections Unknown Level (SBR09 value - OF or 11)**

05 PRIVATE HEALTH INSURANCE (other than Blue Cross/Blue Shield)

1. Managed Care (Private)
- 1 Commercial Managed Care - HMO (SBR09 value - HM)
- 2 Commercial Managed Care - PPO (SBR09 value - 12)
- 3 Commercial Managed Care - POS (SBR09 value - 13)
- 4 Exclusive Provider Organization (SBR09 value - 14)
- 9 Managed Care, Other (non HMO)

2. Private Health Insurance - Indemnity (SBR09 value - 15)
- 1 Indemnity (e.g. high option/low option)
- 2 ERISA ASO plan
- 3 Commercial Indemnity
- 4 Self-insured (ERISA) ASO plan
- 5 Medicare supplemental policy (as second payor)

3. Commercial (Indemnity or Managed Care, unspecified) (SBR09 value - CI or 15)
4. Organized Delivery System
5. Small Employer Purchasing Group
9. Other Private Insurance, not BC or Kaiser

06 BLUE CROSS/BLUE SHIELD (SBR09 value - BL)

1. BC Managed Care
- 1 BC Managed Care - HMO
- 2 BC Managed Care - PPO
- 3 BC Managed Care - POS
- 9 BC Managed Care - Other

2. BC Indemnity (SBR09 value - BL or 15)
3. BC (Indemnity or Managed Care) - Out of State (SBR09 value - BL or 15)
4. BC (Indemnity or Managed Care) - Unspecified (SBR09 value - BL or 15)
9. BC (Indemnity or Managed Care) - Other

07 MANAGED CARE, UNSPECIFIED

(to be used only if one can't distinguish public from private)

1. HMO (SBR09 value - HM)
2. PPO (SBR09 value - 12)
3. POS (SBR09 value - 13)
9. Other Managed Care, Unknown if public or private

08 NOPAYMENT from an Organization/Agency/Program/Private Payor Listed

1. Self-pay (SBR09 value - 09)
2. No Charge
- 1 Charity
- 2 Professional Courtesy
- 3 Research/Clinical Trial

3. Refusal to Pay/Bad Debt
4. Hill Burton Free Care
5. Research/Donor
9. No Payment, Other

09 MISCELLANEOUS/OTHER

1. Foreign National
2. Other (Non-government) (SBR09 value - 11)
3. Disability Insurance (SBR09 value - DS)

4. **Long-term Care Insurance**
5. **Worker's Compensation (SBR09 value - WC)**
   1 Worker's Comp Fee-for-Service
   2 Worker's Comp HMO
   3 Worker's Comp Other Managed Care
6. **Auto Insurance (no fault) (SBR09 value - AM)**
7. **Other, not specified**
8. **Other specified (includes Hospice - Unspecified plan)**
9. **Other Unspecified**

ZZZ Missing Data

5. REMINDER

Remark Codes are updated:
4/1, includes requests from November thru February
8/1, includes requests from March thru June.
12/1, includes requests from July thru October

6. Provider Organizations Form Coalition to Tackle the 835 Transaction Standard

A group of provider organizations, partners, and subject matter experts has formed the 835 Coalition to identify common problems and issues surrounding the 835 electronic transaction standard. The HIPAA administrative simplification savings in the use of the electronic remittance standard have not been fully realized. The coalition is seeking to identify and overcome the barriers and operational issues that are preventing effective use of this transaction.

Read more
***get the coalition website…